WOMEN'S HEALTH SCREEN

Name _____ Birth Date_____ Today's Date_____

Current health problems/concerns:_____

_____

Current medications, prescription (i.e. hormones) or over-the-counter _____

General Health (check any that apply):

Chronic fatigue___ Irritability___ Shortness of breath ___ Headaches___ Bone pain ___ Memory fails____

Have you experienced unintentional weight loss or gain of 10 pounds or more in the last three months ____

Gynecological History:

Date of last gynecological exam (PAP, mammogram)_____Results_____

Date of last menstrual cycle _____ Length of cycle _____ Interval of time between cycles_____

Any recent changes in normal menstrual flow _____ Age of first period _____

Form of birth control _____ Number of children _____ Number of pregnancies _____

C-section _____ Surgical menopause, date _____ Describe Surgery_____

Endometriosis___ Infertility___ Fibrocystic Breasts___ Fibroids/Ovarian Cysts___Reproductive cancer___

Pelvic Inflammatory Disease___Vaginal Infections ___ Vaginal Candidiasis___ Genital Herpes___ STD__

Family Medical History (check any that apply):

Breast or other cancers ____ Cardiovascular disease____ Osteoporosis ____ Obesity_____ Alcoholism___

Mental Illness/Depression _____ Alzheimer's _____ Diabetes _____ Arthritis _____ Stroke _____

Lifestyle & Diet:

Rate the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) _____

Identify the major causes _____

Do you eat (check any that apply):

Sweets, sodas, ice cream ____ Fried foods ____Whole grains, legumes, cereals ____ Fruits/vegetables____

List your 4 favorite foods _____

Do you (check any that apply):

Diet frequently ____ Skip meals ____ How many meals do you eat per day_____ Dine out regularly_____

Use tobacco/smoke cigarettes ____ How many cigarettes per day _____ Exposed to passive smoke _____

Drink coffee_____ # cups per day_____ Strong ____ Mild _____ Decaffeinated _____Eat Chocolate_____

Drink alcoholic beverages _____ How many ounces per day/per week _____ Preference_____

Exercise daily_____ How many times per week/activity: _____

Do you restrict your intake of or avoid completely (check any that apply):

Dietary fat ____ Dairy products ____ Animal protein ____ Salt ____ Fiber _____ All animal foods_____

Check the symptoms you experience regularly <u>one to two weeks before</u> your period:

Part 1

1.____ Anxiety
2.____ Irritability
3.____ Nervous tension
4.____ Aggressive or hostile toward family/friends
5.____ Engage in self destructive behavior
6.____ Weight gain
7.____ Water retention
8.____ Abdominal bloating
9.____ Tender, swollen and/or painful breasts
10.____ Breast lumps increase in size and tenderness
11.____ Discharge from nipples
12.____ Craving for sweets
13.____ Increased appetite
14.____ Heart palpitations
15.____ Fatigue
16.____ Headaches
17.____ Shaky or clumsy
18.____ Depressed
19.____ Withdrawn
20.____ Confused
21.____ Forgetful
22.____ Insomnia/difficulty sleeping

*Check the symptoms and/or behaviors that occur **during your period** with a* frequency *or intensity that affects your daily activities:*

Part 2

1.___ Cramping in lower abdomen or pelvic area
2.___ Sharp intermittent pain
3.___ Dull aching pain
4.___ Upset stomach
5.___ Diarrhea
6.___ Nausea or vomiting
7.___ Low back aches
8.___ Headaches
9.___ Difficulty concentrating
10.___ Accident prone
11.___ Unusual fatigue (take naps)
12.___ Decreased productivity
13.___ Weight gain
14.___ Painful and/or swollen breasts
15.___ Irritability
16.___ Mood swings
17.___ Depression
18.___ Painful intercourse

*Check off any of the following statements **that describe** your menstrual cycle, energy level or reproductive function:*

Part 3

1.___ Heavy prolonged menstrual bleeding/clotting
2.___ Menstrual bleeding that lasts longer than 5 days
3.___ Absence of periods for 3 months or more
4.___ Vaginal itching, burning, dryness
5.___ Menstruation that occurs too frequently (every 21-24 days)
6.___ Irregular periods (once every three to six months)
7.___ Frequently skip periods
8.___ Menstrual cycle every 36 days or longer
9___ Unusually light or heavy periods
10.___ Unusually light menstrual flow - "spotting"
11.___ Menses last three days and are light
12.___ Bleeding or spotting between period s
13.___ Bleeding between periods is light - "staining"
14.___ Bleeding between periods is heavy and/or clots
15.___ Abnormal vaginal discharge
16.___ Frequent urination

*Check any of the following symptoms if they occur **throughout the month** with an intensity or frequency that affects your ability to perform your daily activities or feel good about yourself:*

Part 4

1.___ Decline of vital energy and sense of well-being
2.___ Hot flashes
3.___ Night sweats
4.___ Spontaneous sweating
5.___ Chills
6.___ Depressed
7.___ Irritable
8.___ Anxiety
9.___ Anger
10.___ Mood swings
11.___ Headaches
12.___ Forgetful
13.___ Difficulty concentrating
14.___ Difficulty sleeping
15.___ Urinary problems
16.___ Vaginal problems
17.___ Dry skin
18.___ Bleeding between periods
19.___ Irregular periods
20.___ Stopped menstruating
21.___ Joint and muscle pain
22.___ Change in sexual desire
23.___ Difficulty with orgasm
24.___ Painful intercourse
25.___ Loss of muscle tone
26.___ Vaginal bleeding any time
27.___ Vaginal bleeding after sex
28.___ Vaginal discharge

Additional Comments: